SHICK Senior Health Insurance Counseling for Kansas

Medicare Prescription Drug Coverage Worksheet

K-STATE Research and Extension | River Valley District

Please complete both sides of this form and return to the River Valley Extension District Office as soon as possible, but no later than one week before your appointment. Please bring any letters you received recently from Social Security and Medicare, as well as your current Medicare card, to your appointment.

1. **What is your name as it appears on your Medicare card?**

   _____

2. **What is your Medicare Claim Number?**

   _____

3. **What is the effective date for your Medicare?**

   Hospital (Part A) _____
   Month/Date/Year

   Medical (Part B) _____
   Month/Date/Year

4. **What is your date of birth?** _____
   Month/Date/Year

5. **What is your address?** _____

   City, State, Zip Code? _____

   Phone Number? _____

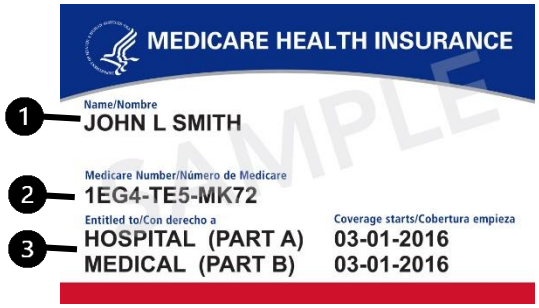
   Email Address? _____

   What county do you live in? _____

6. **List the pharmacy or pharmacies you use. Include the pharmacy name and city location.**

   _____

   _____



Office Staff Use Only

Appt Date: _____

Appt Time: _____

Counselor: _____

Date Received in Office: _____

MyMedicare.gov Information

Username: _____

Password: _____

Security Question: _____

Answer: _____

7. **Do you have a MyMedicare.gov account?**

   _____ Yes, it's already on file with Extension Office. Skip to Question 8.

   _____ Yes, my information is below.

   Username: _____ Password: _____

   Security Question: _____ Answer: _____

   _____ No, please create an account for me.

8. **Name of Current Part D Plan:** _____

MUST COMPLETE INFORMATION ON BACK

9. **Do you qualify for Extra Help with your medications?** _____ Yes _____ No

If you qualify for Extra Help, some or all your prescription drugs costs will be covered.

Extra Help is available if income and assets are:

- Individual - **income** at or below $19,320 per year ($1,610 per month)
  - **assets** below $14,790 (excludes primary residence and one vehicle(s)
- Married Couple - **income** at or below $26,130 per year ($2,177 per month)
  - **assets** below $29,520 (excludes primary residence and vehicle(s)

10. **List the prescription drugs you currently take. Be specific as possible. Include the dosage, type, and how often you take it per month. Print clearly. If you need additional space, please attach a piece of paper. You may attach a printout of your drugs from your doctor or pharmacy.**

Prescription Drug Name	**Dosage/Type** *Ex: 30 mg/capsule*	**30 Day Quantity** *Ex: 2 pills a day = 60*

Disclaimer: I confirm that all the information I have provided is truthful and accurate.

I give permission to the SHICK Counselors and River Valley Extension District staff to use my MyMedicare.gov username and password. If I do not have a MyMedicare.gov account set up, I give permission to the SHICK Counselors and River Valley Extension District staff to create a username, password, and security question. I understand that I will receive a letter or email in the next few weeks stating that an account has been created for me.

Signature: _____ **Date:** _____

K-STATE Research and Extension
River Valley District

For more information on SHICK or Medicare, please contact:
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